EXHIBIT 3-A:

BON Report Page(s)

- Brixon interfered with cancellation of ABG test
- ECU reported White's death as "not clear."

Attorney Work Product – Privileged Communication
Internal Working Notes

Licensee Name: Linda Leathers Brixon **License:** NC RN **Certificate Number:** 115824
Date of Birth: [redacted] **Phone Number:** [redacted]
Home Address: [redacted] Greenville, NC 27858

Compact License: multi-state **Other States of Licensure:** none
Date Last Licensed: 07/16/2013 **Initial Licensure:** 08/14/1991 **Expiration Date:** 08/31/2015
License/List# for other license types: LPN Cert#: 39692 (1990)

Nursing Degree(s): ADN **Year earned:** 1991

Prior disciplinary action by BON? No

Complainant: Linda Hofler, RN, Sr. VP Nurse Executive **Phone number:** 252-847-5243
Facility: Vidant Medical Center **Area of practice:** Med/Surg
Dates of Employment: 6/7/1999 – 5/30/2014 **Employed:** weekend option
Previously identified practice deficits/counseling: None
Date of incident: 5/9/2014 **Shift working at time of occurrence:** 7p-7a **Assignment:** 5 patients
Type of assignment: Direct patient care **Incident involved:** 1 patient **Patient Age:** 26
Patient Diagnosis(es): Systemic Lupus, Perineal/perianal abscesses, acute and chronic kidney injury
Patient Outcome: expired
Date of Complaint received: 06/02/2014
Individuals with direct knowledge of incident: Cardiac Monitoring Tech
Practice Concerns/Deficits/Allegations reported: Neglect Failure to assess/evaluate and Withholding Crucial Health Care Information

Employer findings: Risk Management was notified that on the night shift of 5/9/2014, Licensee failed to intervene or act when notified multiple times by a cardiac monitoring tech that the patient was off the monitor.

Carla Owens, Office of General Council for Vidant Medical Center was contacted for additional information regarding their investigation of the reported event. Ms. Owens reported patient KW had been admitted to the hospital on April 16, 2014. On May 9th Ms. Brixon was assigned as the patient's primary nurse on the night shift (7p-7a). Around MN it was reported the patient was confused, pulling off cardiac leads, crawling out of bed and had pulled out her Foley catheter (bulb intact). Ms. Owens reported this was a significant change in condition for this patient. An order for restraints (vest and bilateral wrist) was received from the NP on call. In addition a new order for ABG's was given; however, Ms. Brixon re-contacted the NP and received orders to delay the lab test due to the patient having calmed down.

Ms. Owens stated the cardiac monitoring tech had noted contacting Ms. Brixon (10 times) and the Unit Secretary (3 times) between MN and 05:55a to alert the nurse the patient was not on the cardiac monitor. The last monitor strip was recorded at 11:32p. Each time Ms. Brixon spoke with the tech she explained the patient had either removed the leads or was refusing to be monitored. Ms. Owens stated Ms. Brixon admitted she had walked by the patient's room and determined she was sleeping; however, Ms. Brixon did not record an assessment of the patient. Around 05:55a, a Care Partner entered the patient's room and noted the patient was cold and non-responsive. A code was called, the patient was resuscitated and transferred to MICU where she expired several hours later (1:02 p). The cause of death was reported as "not clear".

Ms. Owens reported Ms. Brixon was unable to identify anything she did or did not do that contributed to the outcome of this patient. She stated that this was Ms. Brixon's first night on duty after having been off